Understanding Reimbursement Issues in Connecticut

A Guide for Health Care Providers and Practice Administration

Connecticut

Example EYLEA® HD (aflibercept) Injection Claim Issues and Applicable State Provisions

Prior Authorization

Issue: Plan delays prior authorization.

Example scenario: Patient is diagnosed and meets medical necessity criteria for EYLEA HD injections. Provider submits a request for prior authorization. Plan has not made a decision.

Connecticut Insurance Code Section 38a-591d states...

For a prospective or concurrent review request, a health carrier shall make a determination within a reasonable period of time appropriate to the covered person's medical condition, but **not later than 15 calendar days** after the date the health carrier receives such request.

Whenever a health carrier **fails to strictly adhere to the requirements of this section** with respect to making utilization review and benefit determination, the covered person shall be deemed to have exhausted the internal grievance process of such health carrier and **may file a request for an external review**, regardless of whether the health carrier asserts it substantially complied with the requirements of this section or that any error it committed was de minimis.

Connecticut Insurance Code Section 38a-510 states...

Each insurance company, or other entity that uses step therapy for such prescription drugs shall establish and disclose to its health care providers a process by which an insured's treating health care provider may request at any time an override of the use of any step therapy drug regimen. Any such override process shall be convenient to use by health care providers, and an override request shall be expeditiously granted when an insured's treating health care provider demonstrates that the drug regimen required under step therapy:

- (A) has been ineffective in the past for treatment of the insured's medical condition,
- (B) is expected to be ineffective based on the known relevant physical or mental characteristics of the insured and the known characteristics of the drug regimen,
- (C) will cause or will likely cause an adverse reaction by or physical harm to the insured, or
- (D) is not in the best interest of the insured, based on medical necessity

Prompt Payment

Issue: Plan delays timely payment pending medical necessity determination.

Example scenario: Patient is diagnosed and meets medical necessity criteria for EYLEA HD injections. Provider submits a claim for EYLEA HD reimbursement, but 31 days later, claim is still pending medical necessity determination.

Connecticut Insurance Code Section 38a-472g states...

Plan cannot reverse or rescind a prior authorization or refuse to pay for such admission, service, procedure, or extension of stay if:

- Plan fails to notify insured or provider **at least 3 business days** before the scheduled date of admission, service, procedure, or extension of stay that the prior authorization has been reversed or rescinded on the basis of medical necessity, fraud, or lack of coverage; and
- Such admission, service, procedure, or extension of stay has taken place based on the prior authorization

Prior authorizations are effective for **at least 60 days** from the date of issuance.

Request for Additional Information

Issue: Subsequent request for additional information.

Example scenario: Provider submits a claim for EYLEA HD reimbursement, but 31 days later, Plan indicates payment of claim is pending receipt of additional information.

Connecticut Insurance Code Section 38a-816 states...

Plan must request additional information **no later than 30 days** for paper claims (notification must be in writing) and **no later than 10 days** for electronic claims.

After receipt of additional information, Plan must pay paper claims **no later than 30 days** and electronic claims **no later than 10 days**.

Filing Deadlines

Issue: Claim is past the filing deadline.

Example scenario: Provider timely submits an EYLEA HD claim. Plan denies the claim for being past the filing deadline.

Group Health Insurance Standards Act, Section 8 states...

Written proof of loss must be furnished to the insurer **within 90 days** after the date of loss. Failure to furnish proof within that time shall not invalidate nor reduce any claim if:

- Furnishing the proof was not reasonably possible within that time; and
- Proof is furnished as soon as reasonably possible **no later than 1 year** from the time proof is required

NOTE: This provision sets forth minimum contractual standards. Provider should check contract for specific requirements.

Provider Appeals

Issue: Provider appeals.

Example scenario: Provider wants to challenge Plan's denial or reduction of an EYLEA HD claim.

Connecticut Insurance Code Sections 38a-591e and 38a-591g state...

Provider must file an internal grievance **within 180 days** of claim denial or reduction. A prospective review must be completed **no later than 30 days**; a retrospective review, **no later than 60 days**.

Provider must file a request for an independent external review **within 120 days** of final adverse determination and pay a filing fee of $25 ($75 annual maximum). Fee will be refunded if the decision favors the provider. Plan must pay for the review.

The independent review organization must complete the review **no later than 45 calendar days** after receipt of the review request. The organization may terminate the review and reverse the adverse determination or final adverse determination if Plan or designated utilization review company fails to provide the necessary documents and information in the time frame specified.

Connecticut Insurance Code Section 38a-591j states...

The commissioner shall receive and investigate all grievances filed against utilization review companies by a covered person. The commissioner shall code, track, and review all grievances. The commissioner may impose such penalties as authorized, in accordance with section 38a-591k.

Complaints regarding these and other payer issues can be made to the Connecticut Insurance Department website.

Visit NavigatingPayerChallenges.com for state-specific and federal legislation or contact your Reimbursement Business Manager (RBM) for more information

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This material is provided for informational purposes only, is subject to change, and should not be construed as legal or medical advice. Use of this information to challenge or appeal a coverage or reimbursement delay and/or denial by a payer is the responsibility of the provider.

Reference: Data on file. Regeneron Pharmaceuticals, Inc.

This information is provided to you by Regeneron, the maker of

EYLEA® HD (aflibercept) Injection 8 mg